1 General Provider and Client Information

1.1 Provider Participation

1.1.1 Provider Participation Requirements

All providers wishing to participate in the Idaho Medicaid program must complete a provider application packet. The packet includes a Medicaid Provider Enrollment Agreement that must be signed by the provider and returned with the enrollment packet to either EDS or the Department of Health and Welfare (DHW).

The provider must meet all applicable state and Idaho DHW licensure/certification and insurance requirements to practice their profession. In addition, the provider qualification requirements for the service(s) to be provided must be met. Information supplied will be used to validate credentials. Other certification/licensure and proof of insurance may be required as provided for in the Rules Governing Medical Assistance (IDAPA 16.03.09).

Continued provider participation is contingent on the ongoing maintenance of such licensure/certification and proof of insurance. The loss of or failure to renew the required license/certification and proof of insurance is cause to terminate a provider's participation in the Idaho Medicaid program.

Additional information about the Idaho administrative rules is available on the Internet: **www.accessidaho.org**

Select: *Laws and Rules: Administrative Rules*

1.1.2 Provider Responsibilities

Providers have the following ongoing responsibilities:

- To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.
- To review and abide by the contents of all Department rules governing the reimbursement of items and services under Medicaid.
- To review periodic provider information releases and/or other program notifications issued by the Department.
- To be licensed, certified, or registered with the appropriate State authority and to provide items and services in accordance with professionally recognized standards.
- To keep the Department advised of the provider's current address.
- To sign every claim form submitted for payment or complete a Signature on File form (including electronic signatures).
- To acknowledge that Medicaid is a secondary payer and agree to first seek payment from other sources.
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge for the difference.
- To comply with the disclosure of ownership requirements.
- To comply with the advanced directives requirement.
- To make records available to the Department upon request.
- To not bill a Medicaid client unless:
  - The client is advised prior to receiving items or services and agrees to be responsible for payment;

- The item or service is not covered by Medicaid and the client is notified prior to receiving the item or service; or
- A third party payment was made to the client, in which case the client may be billed for an amount equal to that payment.

Services provided in excess of the Medicaid service limitations or not covered by Idaho Medicaid may be charged to the client **if** the client is advised prior to receiving the service or item **and** agrees to be responsible for payment. Acceptance of the medical services beyond the limitations is the client's financial responsibility.

1.1.2.1 Medical Record Requirements

Idaho Code Section 56-209h requires that providers generate records at the time the service is delivered, and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. This includes documentation of referrals made or received on behalf of Medicaid clients participating in the Healthy Connections program.

Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

1.1.3 Medicaid Provider Identification Numbers

1.1.3.1 Individual Provider Numbers

A unique, nine-digit provider identification number is assigned to the provider when the provider is approved to serve Medicaid clients. All Medicaid claims are processed based on this provider number.

The nine-digit provider number consists of a randomly selected 7-digit base number followed by a 2-digit service location number. Providers with a single service location will have 00 as the 2-digit service location.

A provider enrolled in the Healthy Connections program as a Primary Care Provider receives a separate Healthy Connections provider number to use when making referrals. See **Section 1.5, Healthy Connections**, for more information on using referral numbers.

1.1.3.2 Multiple Service Locations

A service location is defined as an office or clinic from which the provider renders services. A provider with more than one business address can have a provider number for each service location. The 7-digit base number is the same for all of the provider's service locations. The 2-digit service location number identifies where the service was rendered. Providers have the option of billing with the specific service location number, or can bill all services under their main service location number.

1.1.3.3 Group Practice Provider Numbers

Many providers who offer services to Medicaid clients work within a clinic or group practice to share common business expenses, such as billing. There are four types of group practices:

- Hospital affiliated
- Partnership
- Corporation

- Corporate/partnership

To accommodate these providers, a Medicaid provider number is issued to groups for billing purposes. Individual providers who are members of a group must be enrolled both individually and associated as a member of the group to bill for Medicaid for services. In order to become affiliated as part of a group, the provider must complete the Group and Individual Affiliation Roster and return to Provider Enrollment for processing.

FORM AVAILABLE: Group and Individual Affiliation Rosters are included in the Forms Appendix of this handbook.

The Centers for Medicare & Medicaid Services (CMS) requires the identification of the individual who actually performs a service when billing under a group number. The performing provider's **individual** Medicaid provider number must be on the claim as well as the provider's **group** Medicaid number.

1.1.4 Signature-on-File Form

A provider or authorized agent must sign in the claimant's certification field on all claims. This is an agreement the provider makes to accept payment from Medicaid as payment in full for services rendered. The provider cannot bill the client for an unpaid balance.

FORM AVAILABLE: a signature-on-file form is included in the Forms Appendix of this handbook.

Providers must sign every claim form **or** complete a signature-on-file form. This form is used to submit paper claims without a signature and/or to submit electronic claims. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures.

The signature-on-file form remains on file at EDS and must exactly match the information in the claimant's certification field on the claim form. Never submit paper claims with the claimant's certification field blank. Enter "signature on file" or have the provider sign in field 31 of the CMS 1500, field 85 on the UB92 claim form, field 62 on the ADA 1999/2000 dental form, or field 23 on the pharmacy form. Contact EDS Provider Enrollment for more information, as indicated in **Section 1.2**. To bill electronically, it is necessary to complete a separate certification and authorization agreement.

If you believe that a particular Medicaid provider is abusing the program, you may contact the S/URS unit at:

S/URS Unit
P.O. Box 83720
Boise, Idaho 83720-0036

334-0675 from the Boise calling area

(866) 635-7515 outside the Boise calling area

Monday through Friday (excluding holidays)

8:00 a.m. - 5:00 p.m. MT

1.1.5 Provider Recertification

In accordance with State and Federal regulations, DHW monitors the status of provider participation requirements that apply to each individual provider type. Continued licensure, certification, insurance, and other provider participation requirements are verified on an ongoing basis.

1.1.6 Provider Termination

DHW is required to deny applications for provider status or terminate the provider agreement of any provider suspended from the Medicare program or another state's Medicaid program. DHW may also terminate a provider's Medicaid status when the provider fails to comply with any term or provision of the provider agreement.

Continued provider participation is contingent on the ongoing maintenance of current licensure, certification, or licensure. Failure to renew required licenses, certification, or insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

1.1.7 Surveillance and Utilization Review

The Surveillance/Utilization Review Subsystem (S/URS) is a statistical subsystem within the DHW Medicaid Management Information System

(MMIS) that is used to monitor the utilization patterns of clients and providers participating in the Idaho Medicaid Program.

The S/URS system produces reports that display exceptions to the norm for services of similar providers. When the provider or client services deviate from the norm, the S/URS unit investigates.

Sometimes a deviation can result from the normal care and treatment of a client with an acute or unusual medical condition, but most often a deviation results from a misunderstanding of billing instructions.

1.1.7.1 Provider Program Abuse

The S/URS Unit may occasionally investigate to determine whether a provider is misusing Medicaid. A S/URS analyst may visit the provider of the service to determine the cause of the problem. If appropriate, the provider may receive a warning letter.

S/URS analysts conduct random studies of provider payment histories to detect billing errors and over-utilization. They may perform on-site reviews of records to verify that services billed correspond to services rendered to the client. In more serious cases, a provider may be suspended for a specified time period, terminated from participation in the Medicaid program, or prosecuted.

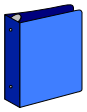
1.2 Services for Providers

1.2.1 Overview

EDS is the fiscal agent for the Idaho Medicaid Program. The primary objective for EDS is to process Medicaid claims efficiently and accurately for Idaho Medicaid providers. The EDS Provider Services Unit enrolls providers into the Idaho Medicaid program and responds to providers' requests for information not currently available through MAVIS. The EDS Provider Relations Unit helps to keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid.

1.2.2 Medicaid Automated Voice Information Service (MAVIS)

For more information



see the **MAVIS Appendix**

To maintain effective and continuous provider communication, EDS offers MAVIS. Providers can obtain detailed client, provider, and claim information through MAVIS. This service lets Idaho Medicaid providers get fast, accurate information on:

- Client eligibility, insurance coverage, and program restrictions
- Procedure code inquiries
- Claim status, last check amount and date
- Provider enrollment status

Providers who use MAVIS will also need a 4-digit security code. The number is only used to access the telephone service. See the MAVIS appendix for more information on the MAVIS security code.

MAVIS is available 24 hours a day including weekends and holidays, except during scheduled system maintenance. MAVIS will inform the caller if the system is unavailable.

Provider representatives are available Monday through Friday from 8:00 a.m. - 6:00 p.m. Mountain Time (MT) (excluding state holidays).

To access MAVIS or to contact EDS Provider Enrollment and other provider services

EDS
P.O. Box 23
Boise, ID 83707-0023

383-4310 from the Boise calling area

(800) 685-3757 outside the Boise calling area

Monday through Friday (excluding holidays)

8:00 a.m. - 6:00 p.m. MT

1.2.3 Provider Enrollment

DHW works with EDS Provider Enrollment to promptly and accurately enroll new providers in the Medicaid program. This team effort ensures efficient Medicaid provider enrollment and claims processing for services rendered to Medicaid clients.

The entities that participate in some part of provider enrollment are:

- Bureau of Medical Care
- Bureau of Behavioral Health
- Bureau of Long Term Care and State Operations
- Bureau of Facility Standards
- Office of Medicaid Automated Systems
- Regional Medicaid Services (all regions)
- Regional Mental Health Authority (all regions)

- Family and Community Services (all regions)
- Developmental Disabilities Program (all regions)
- Healthy Connections
- EDS

Some of these Department entities approve the provider applications for specific provider types and specialties. The provider enrollment packets are reviewed by the provider enrollment team for completeness. Providers are enrolled by the processing of their application, using the information they provide to conduct a credentials investigation.

After the provider is approved for participation in the Medicaid program, the provider information is entered into the computer system, a unique provider number is assigned and the new provider is sent a complete billing package for Medicaid program participation.

1.2.3.1 Provider File Updates

After enrolling, providers must notify Provider Enrollment in writing when there are changes in their status. The written notice must include the provider name and current Medicaid provider number. Status changes include:

- Change in address (or change in any other provider's address, if a group practice)
- New phone number
- Name change (individual, group practice, etc.)
- Change in ownership
- Change in tax identification information
- Change in provider status (voluntary inactive, retired, etc.)

Note: The postal service will not forward mail or checks. All mail and checks are returned to EDS.

To change enrollment information or to apply for additional provider numbers, contact EDS Provider Enrollment.

1.2.4 Provider Service Representatives

EDS provider service representatives are trained to promptly and accurately respond to requests for information on:

- Adjustments
- Billing instructions
- Claim status
- Client benefit information
- Client eligibility information
- Form requests
- Payment information
- Provider participation status information

Provider Service Representatives

To contact an EDS Provider Service Representative, call MAVIS and ask for *AGENT*

383-4310 from the Boise calling area

(800) 685-3757 outside the Boise calling area

Monday through Friday, (excluding holidays) from 8:00 a.m. to 6:00 p.m. MT

- Recoupments
- Third party recovery information

When calling a provider service representative for questions about **claims status**, please have the following information ready:

- billing provider Medicaid identification number
- client's Medicaid identification number
- date(s) of service

When calling a provider service representative for questions about **client eligibility**, have the following information ready:

- billing provider Medicaid identification number
- client's name (first and last)
- client's Medicaid identification number, or date of birth, or Social Security number

1.2.4.1 Provider Handbooks

A provider handbook in a CD format is furnished to all providers enrolled in the Idaho Medicaid program. Providers may also access an electronic copy from the DHW Internet site at www.healthandwelfare.idaho.gov.

The online Idaho Medicaid provider handbooks are updated bi-annually. These updates are designed to keep providers informed of program changes and provide billing instructions. The most current version of the handbook is always available on the Internet.

The provider handbooks are intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the Code or rules prevail.

1.2.4.2 Electronic Billing and Eligibility Software

All Idaho Medicaid providers receive electronic software developed by EDS that is HIPAA-compliant. This software is called *Provider Electronic Solutions* (PES) and it is available free of charge to all Medicaid providers. It can be used for checking Medicaid eligibility and submitting professional, dental, institutional, and pharmacy claims.

Providers may also use vendor software, billing services, and clearinghouses. See **Section 2.2.1, Electronic Claims Submission**, for more information on electronic billing requirements.

1.2.5 Provider Relations Consultants

EDS provider relations consultants (PRCs) help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. PRCs accomplish this by:

- Conducting provider workshops
- Visiting a provider's site to conduct training
- Assisting providers with electronic claims submission

For telephone, fax and addresses for PRCs and SPBU

see the **Directory** at the beginning of this handbook.

All initial communication with consultants should be directed through a provider service representative to determine which PRC can best support a provider's particular needs.

1.2.5.1 Small Provider Billing Unit

The Small Providers Billing Unit (SPBU) is a free, full-service billing assistance program offered by EDS and the Division of Medicaid to Medicaid providers who process 100 claims or fewer per month.

Experienced EDS staff work in conjunction with the Division of Medicaid to assist small providers in the successful creation, submission, and processing of their claims.

The SPBU staff trains and works one-on-one with providers for up to one full year, supplying individualized hands-on claim submission and record reconciliation training. Training is limited to Idaho Medicaid billing.

1.3 Client Eligibility

1.3.1 Overview

Medicaid is a medical assistance program that is jointly funded by the Federal and State governments to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility.

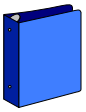
1.3.1.1 Eligibility Requirements

Applicants for Medicaid must meet each of the financial and non-financial requirements of the program in which they will participate. DHW field offices determine Medicaid eligibility. The DHW field offices enroll eligible applicants in the appropriate benefit package.

1.3.1.2 Period of Eligibility

Client eligibility is determined on a month-to-month basis. For example, a client may be eligible during the months of April and June, but ineligible during May. It is strongly recommended that prior to providing services, client eligibility be verified through MAVIS, EDS software (PES), EDS-tested vendor software, or HIPAA-compliant point of service devices (POS). Medicaid only reimburses for services rendered while the client is eligible for Medicaid benefits. Confirmation of eligibility is not available for dates in the future. Refer to Section 1.3.4 for further information on verifying client eligibility.

For more information



See **Section 1.3.3** for verifying eligibility

See **Section 1.3.4** and the **MAVIS Appendix** for more on MAVIS

See section B.1.3 in the **CHIP-B Appendix** for verifying **CHIP-B** eligibility.

1.3.2 Medical Assistance Identification (MAID) Card

A plastic identification card is issued when the client is determined eligible for Medicaid benefits. All Medicaid clients, except ineligible aliens or Presumptive Eligibility (PE) clients, receive a plastic ID card. Possession of a Medicaid identification card does not guarantee Medicaid eligibility. Providers should request the MAID card with additional picture identification and retain copies of this documentation for their records.

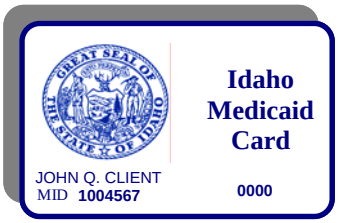
The client's Medicaid identification number is on the card. It is a 7-digit number with no letters or symbols.

There are two valid types of MAID cards:

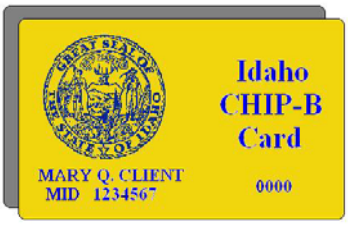
- Any Medicaid client enrolled prior to July 1, 2006 has the white MAID card with "Idaho Medicaid Card" on the front.
- Any client newly enrolled on or after July 1, 2006, will receive a white card with "Idaho Medicaid Card" on the front.
- Any CHIP-B client enrolled prior to the end of the program (June 30, 2006) with a yellow MAID card will be reissued a white card with "Idaho Medicaid Card" on the front.

Note: If the participant presents a yellow CHIP-B card for services delivered through June 30, 2006, refer to the **CHIP-B Appendix** for program coverage information.

Sample Traditional or CHIP-A Card



Sample CHIP-B Card (Not valid after June 30, 2006)



1.3.2.1 Medicaid Exception for Inmates

An inmate of an ineligible public institution can receive Medicaid while an inpatient in a medical institution. The inmate must meet all Medicaid eligibility requirements. Medicaid coverage begins the day the inmate is admitted and ends the day of discharge from the medical institution.

- A person is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities.
- An inmate is an inpatient when he/she is admitted to a hospital, nursing facility, ICF/MR, or if under age twenty-one (21), is admitted to a psychiatric facility.
- An inmate is not an inpatient when receiving care on the premises of a correctional institution.

1.3.3 Covered Benefits

General information on services covered under the Idaho Medicaid program are listed in the booklet, "Medicaid and You" which is available from the Division of Medicaid Department Field Offices or on the Internet in English and Spanish. It is also available on the *Idaho Medicaid Provider Resources CD*.

Refer to Section 3, Provider Guidelines, for specific service coverage and billing details for individual programs and specialties.

1.3.3.1 Medicaid Non-covered Services

Prior to rendering services, providers must inform clients when services are **not** covered under Medicaid. Idaho Medicaid strongly encourages the provider to have the client sign an informed consent regarding any non-covered services. If the client chooses to obtain services not covered by Medicaid, it is the client's responsibility to pay for the services. Please see **Section 1.1.2, Provider Responsibilities,** for additional details.

1.3.4 Verifying Client Eligibility

Providers should verify eligibility on the actual date of service, prior to providing the service. Eligibility information can be accessed four different ways. They are:

- EDS billing software (PES)
- Medicaid Automated Voice Information Service (MAVIS)
- HIPAA-compliant vendor software (tested with EDS)
- HIPAA-compliant point of sale devices (POS)

To obtain eligibility information from one of these systems, submit either the Medicaid Identification Number (MID) or two client identifiers from the following list:

- Social Security Number (SSN)
- Last name, first name
- Date of birth

Client eligibility information available includes Healthy Connections data, Medicaid Special program limitations, certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, and lock-in data.

1.3.4.1 Eligibility Verification

EDS Software (PES)
EDS billing software (PES) can be used to verify Idaho Medicaid eligibility. The software is HIPAA-compliant and can be used to submit an ASC X12 270/271 (version 4010A1) eligibility request and response.

The provider may submit eligibility requests one at a time in interactive mode, or several at a time, which is called "batch" eligibility verification. Interactive eligibility requests are processed and eligibility status is returned within seconds. Batch eligibility verification requires additional time to process. Providers will be notified within 24 hours of a batch request in their submitter's Bulletin Board System (BBS) mailbox. The PES software can also be used for electronic claim submission.

For more information on eligibility requests, see the *Idaho Provider Electronic Solutions (PES) Handbook* available with the PES software.

MAVIS
Providers can use MAVIS to check client eligibility. Eligibility information is available on:

- Healthy Connections,
- Eligibility with Special Programs
- service limits,
- prior authorization, and
- third party liability.

MedicAide newsletters are available on the Internet at:

www2.state.id.us/dhw/medicaid/MedicAide/past_issues.htm

Users may request a fax copy of eligibility information that includes a confirmation number. See the **MAVIS Appendix** for more information.

POS Devices
The HIPAA-compliant point of service (POS) device is offered at no cost to providers and can be used to check client eligibility.

Vendor Supplied Software
Providers may contract with a software vendor and use software supplied by the vendor. Upon request, EDS will furnish the specifications to the vendor free of charge. The specifications assist the vendor in duplicating the program requirements and allow providers to obtain the same information available with software supplied by EDS. All vendor software must have successfully tested with EDS before use.

Providers can check eligibility using vendor software if the software is modified to meet the requirements of the HIPAA ASC X12 270/271, version 4010A1 format, and if the vendor successfully tests the transactions with EDS.

1.3.5 Client Program Abuse/Lock-In Program

DHW reviews Medicaid client utilization to determine if services are being used at a frequency or amount that may result in a level harmful to the client and to identify services that are not medically necessary.

Abuse can include frequent use of emergency room facilities for non-emergent conditions, frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, excessive provider visits, overlapping prescription drugs with the same drug class and drug seeking behavior as identified by a medical professional.

To prevent abuse, DHW has implemented the client lock-in program. Clients identified as abusing or over-utilizing the program may be limited to the use of one physician/provider and one pharmacy. This prevents these clients from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

If a provider suspects a Medicaid client is demonstrating utilization patterns, which may be considered abusive, not medically necessary, potentially endangering the client's health and safety, or drug seeking behavior in obtaining prescription drugs, they should notify the Bureau of Medical Care of their concerns. DHW will review the client's medical history to determine if the client is a candidate for the Lock-In program.

1.3.5.1 Primary Care Physician (PCP)

The Primary Care Physician (PCP) for Lock-in clients is responsible for coordination of routine medical care and making referrals to specialists as necessary. The PCP explains to the Lock-In client all procedures to follow when the office is closed or when there is an urgent or emergency situation. This coordination of care and the client's knowledge of office procedures should help reduce the unnecessary use of the emergency room.

Contact the Bureau of Medical Care at:

(208) 364-1836

If the client needs to see a physician other than the PCP, the PCP gives the client a written referral to another physician or clinic to ensure payment. This also applies to physicians covering for the primary care physician and emergency rooms for non-emergency care. The referred physician must contact the PCP for his/her Idaho Medicaid provider number and enter it on all claims. **To avoid possible abuse, the PCP provider number must not be included on the written referral.**

If a PCP decides that he/she no longer wishes to provide services to the client, send a written notice to the client stating the reasons for dismissal with a copy of the letter sent to the Health Resources Coordinator in your region.

1.3.5.2 Designated Pharmacy

A designated pharmacy has the responsibility of monitoring the client's drug use pattern. The pharmacy should only fill prescriptions from the primary care physician or from referred physicians. **All referrals must be confirmed with the primary care physician before prescriptions are dispensed**.

1.4 Benefit Plan Coverage

1.4.1 Medicaid Enhanced Plan Benefits

Beginning July 1, 2006, Medicaid offers an Enhanced Benefit Plan to children and adults. The Medicaid Enhanced Plan includes all of the benefits found in the Medicaid Basic Plan, plus additional benefits to cover needs of people with disabilities or special health needs. Clients enrolled in this plan will be eligible for the full range of Medicaid covered services.

1.4.2 Medicaid Basic Plan Benefits

1.4.2.1 Overview

Beginning July 1, 2006, Medicaid offers a Basic Benefit Plan to children and adults who do not have disabilities or special health needs. This plan has been designed to achieve and maintain wellness by emphasizing prevention and proactively managing health.

1.4.2.2 Covered Services

Medical coverage under the Medicaid Basic Plan Benefits is limited with some notable differences between the Medicaid Enhanced Plan and Medicaid Basic Plan. A health risk assessment will be an added benefit of the Medicaid Basic Plan Benefits. Children will receive a health risk assessment based on the periodicity set by the EPSDT program. Individuals who have passed the month of their 19th birthday will be allowed one health risk assessment per year.

1.4.2.3 Excluded Services

- EPSDT services will not include Intensive Behavioral Interventions or Private Duty Nursing, except when provided by School-Based Service providers
- Drugs not currently covered under Medicaid
- Rehabilitative services provided by a Developmental Disability facility
- Psychosocial Rehabilitation (PSR) services, except when provided by School-Based Service providers
- Intermediate Care Facility services for the Mentally Retarded (ICF/MR)
- Skilled Nursing Facility Services
- Nursing facility services
- Hospice Care
- Case Management Services, except for EPSDT Service Coordination
- Personal Care Services
- Home and Community Based Services
- Partial Care Treatment

1.4.2.4 Restricted Services

- Mental health inpatient services are limited to 10 days per year whether in a hospital or freestanding facility. Freestanding facilities are limited to individuals under the age of twenty-two (21).
- Outpatient mental health services for certain provider specialties are limited to 26 services per year for all non-inpatient Mental Health services combined. Please refer to Section 3, Provider Guidelines for specific service coverage and limitations for individual programs and specialties.
- EPSDT services are limited to individuals who have not passed the month of their twenty-first (21st) birthday.

1.4.2.5 Third Party Recovery Requirements

All services must be billed to the client's other insurance before billing Medicaid. Please see Section 2.4 Third Party Recovery for billing details.

1.4.2.6 Medical Necessity

Under some circumstances, participants in the Basic Plan with a medical necessity for services in the Enhanced Plan may be eligible for reassignment to the Enhanced Plan. This eligibility determination will be a joint decision made by the appropriate units in the Welfare (Self Reliance) and Medicaid Divisions.

1.4.2.7 Billing Procedures

Follow the same billing practices for any other Medicaid client.

1.4.3 Presumptive Eligibility (PE)

The Idaho Medicaid Program currently has two programs that allow PE:

Pregnant Women: The program was developed as a result of the Federal Catastrophic Health Bill of 1988 to offer medical assistance to pregnant women The program assists Idaho residents not currently receiving medical assistance from the state or county, and do not have sufficient resources for private medical coverage during their pregnancy. PE provides immediate, "presumed" coverage for qualified candidates. The maximum coverage period is 45 days. During this time, the PE client formally applies for another program offered under Medicaid. DHW determines if the pregnant woman is qualified for the Pregnant Women (PW) program or another category of assistance. The goal of the program is to encourage pregnant women to seek prenatal care early in a pregnancy and preserve the health of both mother and infant.

Breast and Cervical Cancer: PE is also available for women who have been initially screened and diagnosed through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

This program allows the state to provide Medicaid benefits to uninsured women between the ages of 40 and 65 when they are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. Certain criteria must be met in order to qualify. See **Section 1.4.3** for further program and eligibility information.

1.4.3.1 Program Procedures

The candidate seeking medical assistance for pregnancy must see an approved provider trained and certified by the Department, such as a health district or hospital. Additionally, providers qualified to perform PW PE determination must meet the eligibility criteria listed in Section 1920 of the Social Security Act.

Potential PE candidates answer preliminary program questions from the provider to determine if they are eligible for the program. These qualifications are determined by federal guidelines.

The **PE candidate for the Pregnant Woman (PW) program** must have a medically verified pregnancy and have financial resources that fall within specific income levels. Eligibility for pregnancy services under the PE program is determined as follows:

1. Client and provider complete program questions and determine if client is eligible for the PE program.
2. Client's local field office receives the application for services from the provider, processes it, and issues a Medicaid number for client's PE eligibility period.
3. Client's Presumptive Eligibility period ends after a maximum coverage period of 45 days or sooner if the candidate is eligible for PW (Pregnant Women) or another Medicaid program.

Follow these steps to submit your claims:

1. Verify the client's eligibility using MAVIS or electronic software. See Section 1.3.4, for instructions on verifying eligibility.
2. Submit your claim with the client's Medicaid ID number

The **PE candidate for the breast and cervical cancer program** must be screened through a Local Women's Health Check office (usually the District Health Department) and test positive for a breast or cervical cancerous or pre-cancerous condition that requires treatment.

1.4.3.2 Covered Services

Medical coverage for the PW program during the presumptive eligibility period is restricted to ambulatory outpatient, pregnancy-related services only. Pregnancy related services may be rendered by any qualified Medicaid provider.

Routine prenatal services are covered, as well as some additional services such as nutrition counseling, risk-reduction follow-up and social service counseling.

Providers are not required to bill another insurance resource, if it exists, before billing Medicaid for prenatal services during the PE period.

Women who have PE for the breast and cervical cancer program at the time of service are eligible for Medicaid benefits during the PE period.

1.4.3.3 Medical Necessity

To bill PE services for the PW program that are not clearly pregnancy-related, attach medical necessity documentation to a paper claim form explaining how the service is pregnancy-related. Services not clearly

pregnancy-related will be denied if documentation of medical necessity is not provided.

If the PE client is referred to the hospital for lab testing or x-rays and the services are not clearly pregnancy-related, give the client a completed PW Medical Necessity Form. The client takes this form to the next provider to establish the service as pregnancy-related. Refer to Appendix D for a copy of the PW Medical Necessity form.

1.4.3.4 Excluded Services

The PE program does not cover PW inpatient services. Medicaid does not pay for any type of abortion for clients on the PE program. Also, PE clients are not covered for any delivery services. Services not covered under Medicaid are the client's responsibility. If the PE client has applied for the PW program or any other Medicaid program, and is determined eligible, hospital inpatient services may be covered.

No specific services are excluded for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

1.4.4 Pregnant Women (PW)

1.4.4.1 Overview

Medicaid offers extended eligibility and additional services to all women covered by Medicaid during their pregnancy and postpartum period. The PW program is for pregnancy-related services only and is available to pregnant women who meet the eligibility requirements. This coverage ends on the last day of the month in which the 60th day after delivery occurs.

Medicaid developed the PW program to help ensure that all women have access to prenatal and postpartum care. The ultimate goal is to ensure the health of mothers and infants.

1.4.4.2 Covered Services

Medical coverage under PW is restricted to pregnancy-related services only. Normal prenatal services are covered as well as some additional services such as nutrition counseling, risk reduction follow-up, and social service counseling. Pregnancy related services are those necessary for the health of the mother or fetus; or services that become necessary because of the pregnancy.

Chiropractic and Physical Therapy services for clients enrolled in the PW program must be billed on a paper claim with attached documentation explaining the medical necessity and how the services are pregnancy related.

Dental coverage under PW is limited to the relief of pain and infection that could affect the outcome of the pregnancy. See ***Idaho Medicaid Provider Handbook, Dental Program Guidelines, Section 3***, for a description of the specific dental codes covered for women participating in the PW program.

All family planning services normally covered under Medicaid, including sterilization, are covered under the PW Program. When billing for sterilization, all appropriate consent forms must be attached, along with documentation/justification that the service was performed during the two month post-partum period. These services are covered up to the last day of

the month in which the 60th day after delivery falls. Family planning services are only covered during the 60-day postpartum period. For example:

Delivery Date	30 Days Postpartum	60 Days Postpartum	PW Coverage Ends On
09/15/2001	10/15/2001	11/14/2001	11/30/2001
12/02/2001	01/01/2002	01/31/2002	01/31/2002

1.4.4.3 Non-covered Services

Optical benefits are not normally covered as a part of the PW program. A physician must provide medical necessity documentation if billing for optical services that directly affect the pregnancy or if the symptoms being treated are a direct result of the pregnancy.

1.4.4.4 Third Party Recovery Requirements

Prenatal services, delivery, and all postpartum services must be billed to the participant's other insurance before billing Medicaid. Please see Section 2.4 Third Party Recovery for billing details.

1.4.4.5 Medical Necessity

FORM AVAILABLE: a Medical Necessity form is included in the Forms Appendix of this handbook.

If the services are not clearly pregnancy-related, attach medical necessity documentation to the paper claim to explain how the service is pregnancy-related. The information from the medical necessity documentation will be used to determine if the service provided relates to the pregnancy. It is not a guarantee that the service will be reimbursed. Services not clearly pregnancy related will be denied if documentation of medical necessity is not provided.

The EDS medical consultant reviews each claim on a case-by-case basis. EDS may deny a claim with the reason, "This PW client's charge has been reviewed by the EDS medical consultant and denied."

To request further review, write:

Division of Medicaid
Bureau of Medical Care
P.O. Box 83720
Boise, ID 83720-0036

1.4.4.6 Excluded Services

Excluded services include treatment that is not a direct result of, or which does not directly affect the pregnancy.

1.4.4.7 Billing Procedures

Follow the same billing practices for a PW client as for any other pregnant Medicaid client. All services must be pregnancy-related.

1.4.5 Breast and Cervical Cancer

1.4.5.1 Program Policy

A woman not otherwise eligible for Medicaid who meets certain conditions may be eligible for Medicaid benefits for the duration of her cancer treatment.

1.4.5.2 Eligibility

In order to be eligible, the participant must be initially screened and diagnosed through a Local Women's Health Check office (usually the District Health Department) as a representative of the Centers for Disease Control and Prevention.

The participant can be presumed eligible before a formal Medicaid determination under Presumptive Eligibility, as described in **Section 1.4.1.** Although Medicaid resource limits do not apply, the participant must:

- meet the designated income limit
- be diagnosed with breast or cervical cancer through the Women's Health Check program.
- be at least forty (40) years old and under the age of sixty-five (65)
- have no creditable insurance (if insured, the plan does not cover the same type of cancer)
- be an Idaho resident
- provide a valid Social Security number
- be a U.S. citizen or meet requirement for legal non-citizen
- not reside in an ineligible institution
- not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole
- be willing to cooperate with the department to secure medical or child support services, unless the participant has good cause

1.4.5.3 Covered Services

Women who qualify for this program are eligible for Medicaid benefits during the treatment phase of their cancer care.

1.4.5.4 Stages of Treatment

Coverage for primary cancer treatment may include:

- medical and surgical services
- pre-cancerous conditions, and
- early stage cancer

Adjuvant cancer treatment involving radiation or systemic chemotherapy included in the treatment plan, are also covered.

1.4.5.5 End of Treatment

Cancer treatment ends when a participant's plan of care reflects a status of surveillance, follow-up, or maintenance. Additionally, benefits will end if a participant's treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

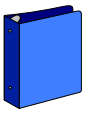
1.4.6 Medicare Savings Program

1.4.6.1 Program Policy

The State has agreements with the Social Security Administration (SSA) and Centers for Medicare and Medicaid Services (CMS), which allows the State to enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and the Supplementary Medical Insurance (also referred to as SMI or Medicare Part B). The agreements allow Medicaid clients who are entitled to Medicare to have their Part A and/or Part B Medicare premiums paid by Medicaid. Clients do not have to be 65 years old or older to be eligible for Medicare. The statutory authority for the Medicare Savings Program is §1843 of the Social Security Act and Medicare Catastrophic Act of 1988.

The purpose of these arrangements is to permit the State to provide Medicare protection to certain groups of needy individuals as part of its total assistance plan. The arrangements transfer the partially State-funded medical costs for this population from Title XIX Medicaid program to the Title XVIII Medicare program, which is funded by the federal government and by payment of individual premiums. Federal financial participation (FFP) is available through the Medicaid program to assist the States with the premium payment for certain groups of needy individuals.

For more information



see **Section 2.5.9** for specific billing information on Qualified Medicare Beneficiary

There are two (2) types of Part A Medicare Savings Program participation:

- Regular Type Part A
- Qualified Disabled Working Individual (QDWI) Part A

1.4.6.2 Part A Medicare Savings Program

This program is for individuals that are not entitled to premium-free Medicare Part A benefits. These individuals must apply for Medicare with the Social Security Administration and be determined eligible for self-pay type Medicare.

These individuals have a Medicare claim number with a Beneficiary Identification Code (BIC) of "M". This code is found at the end of the Medicare claim number.

Medicaid pays the Medicare Part A premium, coinsurance, and deductible only.

1.4.6.3 Qualified Disabled Working Individual Part A Medicare Savings

Qualified Disabled Working Individual (QDWI) does not include State payment of Part B Medicare premiums.

QDWI individuals have lost Medicare Part A (HI) entitlement solely because of work, and are entitled to enroll in Part A Medicare under §1818A of the Social Security Act.

Medicaid pays the Medicare premium, coinsurance, and deductible only.

1.4.6.4 Part B Medicare Savings Program

There are several types of participation in the Part B Medicare Savings Program in Idaho:

Participation	Short Name	Description
Qualified Medicare Beneficiary	QMB	• Individual is entitled to Medicare and meets the income limits. • Medicaid pays the Medicare premium, and up to the lower allowed amount for the medical service (Medicare/Medicaid).
Qualified Medicare Beneficiary with Medicaid	QMB+ (QMB Plus)	• Individual is entitled to Medicare, meets income limits, and has open Medicaid eligibility. • Medicaid pays the Medicare premium, up to the lower allowed amount for the medical service (Medicare/Medicaid) • Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Specified Low Income Medicare Beneficiary	SLMB	• Individual is entitled to Medicare and is within income limits. • Medicaid pays the Medicare premiums only.
Specified Low Income Medicare Beneficiary with Medicaid eligibility	SLMB+ (SLMB Plus)	• Individual is entitled to Medicare, within income limits and on Medicaid eligibility. • Medicaid pays the Medicare premium, coinsurance, deductible. • Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Medicaid (with deemed Cash Assistance Recipient)		• Individual is entitled to Medicare, within income limits and on Medicaid eligibility. • Medicaid pays the Medicare premium, coinsurance, deductible • Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Medicaid – Non-Cash (also known as Medical Assistance Only)	MAO	• Individual is entitled to Medicare, within income limits and on Medicaid eligibility. • Medicaid pays the Medicare premium, up to the lower allowed amount for the medical service (Medicare/Medicaid) • Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Qualified Individual 1	QI1	• Individual is entitled to Medicare and within income limits. • Medicaid pays the Medicare premiums only.

1.4.6.5 Medicaid Pays a Portion of the Dually Eligible Medicare Beneficiaries

Dually eligible individuals are persons who are entitled to Medicare and are eligible for Medicaid. Dually eligible individuals are eligible for Medicare and Medicaid benefits under the category of assistance programs for which they qualify. Dually eligible clients receive Medicare premium coverage and coinsurance/deductible reimbursement consideration for all Medicare covered services. Pharmacy items or other services not covered by their Medicare benefits may be covered under their Medicaid benefits. Bill Medicare first if both programs cover a service.

1.4.6.6 Qualified Medicare Beneficiary

Qualified Medicare Beneficiary (QMBs) clients are only eligible for Medicare paid claims, up to the lower allowed amount (Medicare/Medicaid) from Idaho Medicaid. Claims filed for Medicare's coinsurance and deductible are called "crossover claims". The Medicaid Remittance Advice (RA) shows the payment of these charges on the "Professional Crossover Claim" page on the first detail line.

Submit each claim form with its own copy of the corresponding Medicare Remittance Notice (MRN) attached. All crossover claims submitted on paper must match the Medicare MRN exactly.

Submit two separate claims to Medicaid – one claim for the crossover portion and the second claim for the non-covered Medicare services when a MRN contains covered and non-covered services (for dually eligible QMB clients only). Both must have a copy of the MRN included. Indicate "Medicare non-covered benefit" in field 19 of the CMS 1500, field 84 of the UB92, field 38 of the 1994 ADA, or field 61 of the 1999 ADA claim forms.

1.4.7 Medicare Part D

The Medicare Modernization Act (MMA) was signed into law December 8, 2003. Under the law, dual eligibles will no longer receive their drug coverage from Medicaid and instead will select or be auto enrolled in private Medicare prescription drug plans effective January 1, 2006. Medicaid may still cover some essential drugs not covered under the Medicare Part D Prescription Drug plan. Medicare must be billed prior to submitting drug claims to Medicaid.

1.4.8 Otherwise Ineligible Aliens (OIA)

1.4.8.1 Overview

Medicaid offers eligibility to ineligible legal or illegal non-citizens for medical services necessary to treat an emergency medical condition. An emergency medical condition exists when the condition could reasonably be expected to seriously harm the person's health, cause serious impairment to bodily functions, or cause serious dysfunction of any body organ or part, without immediate medical attention.

1.4.8.2 Eligibility

Medicaid eligibility for OIA begins no earlier than the date the client experiences the medical emergency and ends the date the emergency condition stops. The Division of Medicaid determines the beginning and ending dates of eligibility.

1.4.8.3 Covered Services

Obstetrical deliveries are considered emergencies; however, antepartum and postpartum care are not. The Division of Medicaid reviews each request for payment for otherwise ineligible aliens and determines if a medical condition is an emergency.

1.5 Healthy Connections

1.5.1 Overview

Healthy Connections is the Idaho Medicaid program for coordinated or managed care and is a Primary Care Case Management (PCCM) model. The goals of Healthy Connections are to:

- ensure access to healthcare
- provide health education
- promote continuity of care
- strengthen the physician/patient relationship
- achieve healthy outcomes for participants
- achieve cost efficiencies

Providers who render services that require a referral from the Primary Care Provider (PCP), when the client is enrolled in the Healthy Connections program, must obtain the referral from the assigned Healthy Connections provider. Both the PCP and the provider to whom the referral has been made must keep documentation of the referral.

In 2002 Healthy Connections became a mandatory program. Client enrollment in the program is required in the majority of counties statewide.

1.5.2 Provider Enrollment

Idaho Medicaid providers of primary care services can enroll in Healthy Connections by signing a Coordinated Care provider agreement with the Department. For an Agreement, contact the local Health Resources Coordinator (HRC) for the Healthy Connections program in your region. Addresses and telephone numbers are listed in the Directory of this Provider Handbook (Page viii)

Healthy Connections PCPs receive a monthly case management fee of $3.50 for each enrolled client. PCPs participating in Healthy Connections agree to provide 24-hour telephone coverage and exercise their best efforts to monitor and manage client's care, provide primary care services, and make referrals when medically necessary covered services cannot be provided by the PCP.

1.5.3 Client Enrollment

Medicaid clients choose or are assigned a primary care provider during the application process. This change in the enrollment process was made to facilitate a quicker and more efficient enrollment in the Healthy Connections program. Each qualified family member can choose his or her own primary care provider. Family members are not required to choose the same primary care provider. Clients may request a change in their provider by notifying the HRC no later than the 20th of any month. The change will be effective the first day of the following month. Additional enrollment information can be found in Appendix A, Healthy Connections, Section A. 1. 3.

In counties where Healthy Connections operates as a mandatory program, clients who are non-responsive in selecting a PCP will be assigned to one.

Some clients meet criteria to be exempt from mandatory enrollment in the program.

Enrollment in Healthy Connections always begins the first day of the month. Clients receive written notice advising them of the name, phone number and address of their Primary Care Provider.

1.5.4 Referrals

1.5.4.1 Overview

If a Healthy Connections PCP feels specialized services are necessary, the client is referred to a specialist who is enrolled as a provider in the Idaho Medicaid program and can provide Medicaid covered services. Medicaid will pay for the covered services performed by another provider only after the PCP has provided the appropriate referral.

Prior to performing any services, all Medicaid providers should check to see if the client is Medicaid eligible and if they are enrolled in Healthy Connections. When obtaining eligibility information, the provider should also request the name and telephone number of the HC provider in order to obtain the appropriate referral to provide services.

- All services require a referral except for those listed in Section 1.5.4.3.
- All services requiring a PCP referral that are provided without a referral are considered non-covered services. A provider rendering non-covered services must advise the client preferably in writing prior to providing such services.

1.5.4.2 Referral Requirements

A referral is a doctor's order for services. Healthy Connections PCPs can make a referral for a patient by:

- Filling out a referral form and giving it to the patient (to take with them to the specialist) or sending it directly to the specialist
- Ordering services on a prescription pad
- Calling orders to the specialist

The details of the referral are to be documented in the patient's permanent record by both the referring provider and the provider to whom the referral was made. The record should include:

- Who made the referral
- Date of the referral
- Scope of services to be provided
- Referral number (this is the referring provider's Idaho Medicaid Healthy Connections referral number and is used for billing purposes)
- Duration of the referral

A specialist receiving a referral may be authorized by the PCP to order additional services, on behalf of the PCP. For example, a referral to diagnose and treat authorizes the specialist to order tests (i.e., lab, x-ray, etc) to

accomplish diagnosis. In these cases, the specialist is to forward the referral information (including the referral number) to the appropriate service providers. Questions regarding the scope of a referral should be directed to the PCP.

Developmental disabilities and mental health services delivered under a plan of care also require a referral from the PCP, in addition to any other program prior authorization requirements. The services must be a covered benefit of the client's benefit plan. DHW staff or designated delegates overseeing service delivery are authorized to forward appropriate referral information to the various providers for service indicated in the approved plan of care.

At a minimum, referrals for "on-going" services should be renewed annually.

Specialists or providers who receive Healthy Connection PCP referrals are to report findings/progress back to the PCP unless the PCP indicates they do not want to receive such feedback.

1.5.4.3 Services NOT Requiring a PCP Referral

The following services do not require a referral by the Primary Care Provider (PCP), however, they must be a covered service under the client's benefit plan. If the service is not on this list, it *must* have a referral:

- **Audiology Services**: performed in the office of a certified audiologist. Audiology basic testing requires a physician's order not necessarily from the PCP.
- **Immunizations**: Immunizations do not require a referral when they do not require an office visit. Specialty physician/providers administering immunizations are asked to provide the client's PCP with immunization records to assure continuity of care and avoid duplication of services.
- **Chiropractic Services**: performed in the office. Medicaid will pay for a total of twenty-four (24) manipulations during any calendar year for the treatment of misalignment of the spine (subluxation).**(On dates of service prior to 7/1/2006, this was not a covered service for clients formerly enrolled as CHIP-B clients.)**
- **Dental Services**: performed in the office. However, procedures performed in an inpatient-outpatient hospital setting or ambulatory surgical center setting may require a PA and does require a referral from the PCP. The referral should identify the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician and lab work. **(On dates of service prior to 7/1/2006, this was not a covered service for clients formerly enrolled as CHIP-B clients.)**
- **Emergency Department**: services provided in an emergency department of a hospital
- **Family Planning Services**: provided by district health departments or other agencies providing counseling and supplies to prevent pregnancy.
- **ICFs/MR Services** (**These services are not covered for Medicaid Basic Plan Benefits clients)**
- **Indian Health Clinic Services**
- **Influenza Shots**

- **Nursing Facility Services (These services are not covered for Medicaid Basic Plan Benefits clients).**
- **Personal Care Services (These services are not covered for Medicaid Basic Plan Benefits clients).**
- **Personal Care Services Case Management (*These services are not covered for Medicaid Basic Plan Benefits clients*.)**
- **Pharmacy Services**: for prescription drugs only.
- **Podiatry Services**: performed in the office. However, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician and lab work. **(On dates of service prior to 7/1/2006, this was not a covered service for clients formerly enrolled as CHIP-B clients.)**
- **School District Services**: Includes all health related services provided by a school district under an Individual Education Plan (IEP). **(On dates of service prior to 7/1/2006, this was not a covered service for clients formerly enrolled as CHIP-B clients.)**
- **Screening Mammography**: Limited to one (1) per calendar year for women age 40 or older.
- **Sexually Transmitted Disease Testing**
- **Non-Emergent Transportation Services**
- **Vision Services**: performed in the offices of ophthalmologists and optometrists, including eyeglasses. However, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician and lab work.
- **Waiver Services for the Aged and Disabled/Traumatic Brain Injury. (These services are not covered for Medicaid Basic Plan Benefits clients).**

1.5.4.4 Reimbursement for Services Requiring Referral

When a Healthy Connections PCP refers a client to another provider or institution, the receiving provider or institution must do one of the following to receive reimbursement:

- List the referring PCP's Healthy Connections referral number in field 83 of the UB 92 OR
- Enter the PCP's name in field 17 and their Healthy Connections referral number in field 17A of the CMS 1500.
- Enter the information in the appropriate fields for electronic submissions. See PES handbook if using Idaho Medicaid software.

If a primary care provider has completed a referral form, a copy of the form should reside in the client file in both providers' offices. If another form of physician order or referral was used, such as a phone call or standing order, this information is also required to be in the client files and should include documentation of the referral or physician order.

Use of a PCP's Healthy Connections provider number indicates that the billing provider has obtained and documented the referral in the client's record. *Using a referral number without obtaining a referral is considered fraudulent.*

1.5.4.5 Program Liaison

The Healthy Connections program provides staff to help you resolve program related problems you may encounter. Please contact your local Health Resources Coordinator to obtain information, training, or to answer questions. Refer to the *Idaho Medicaid Provider Handbook* Directory for specific contact information.

1.6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

1.6.1 Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was designed to provide periodic screening and treatment of Medicaid eligible children for early detection of medical or developmental problems.

1.6.2 Medical Screen Eligibility

All Medicaid eligible children ages birth through 21 are eligible for EPSDT screenings. Clients are eligible for an EPSDT screening through the end of the month of their 21st birthday. Parents will receive an informational letter reminding them their child is eligible for an EPSDT screening when the child moves into a new age category. However, informational letters will not be sent to parents of certain pregnant women/children who are under the age of 21.

1.6.3 Content of EPSDT Medical Screen

DHW uses the American Academy of Pediatrics Periodicity Schedule to determine what tests are needed at listed intervals. The screening must include the appropriate laboratory tests for that periodicity schedule.

Special chemical, immunologic, and endocrine testing for newborns to identify inborn errors such as metabolism disorders, sickle cell anemia, and lead poisoning is usually carried out upon specific indications. Testing other than newborns is at the discretion of the physician.

1.6.4 EPSDT Screening/Immunization Schedule

Screening and Immunization reviews must be appropriate to age and health. The following tables show age-appropriate health history and health screening services.

If a child receives care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Adolescent related issues (psychosocial, emotional, substance use and reproductive health) may necessitate more frequent health supervision.

1.6.4.1 Infant EPSDT Screening

Description	Notes	By 1 Mo.	2 Mos.	4 Mos.	6 Mos.	9 Mos.	12 Mos.
History	**2**						
Initial / Interval	**2**	**X**	**X**	**X**	**X**	**X**	**X**
Measurements	**2**						
Height and Weight	**2**	**X**	**X**	**X**	**X**	**X**	**X**
Head Circumference	**2**	**X**	**X**	**X**	**X**	**X**	**X**
Blood Pressure	**2**						
Sensory Screening	**2**						
Vision	**2**	**S**	**S**	**S**	**S**	**S**	**S**
Hearing	**2**	**S**	**S**	**S**	**S**	**S**	**S**
Development/ Behavior Assessment	**2, 4**	**X**	**X**	**X**	**X**	**X**	**X**
Physical Examination	**2, 5**	**X**	**X**	**X**	**X**	**X**	**X**
General Procedures	**2, 6**						
Hereditary/Metabolic Screening	**2, 7**	**X**					
Immunization	**2, 8**	**X**	**X**	**X**	**X**	**X**	**X**
Hematocrit or Hemoglobin	**2, 10**					**X**	
Urinalysis	**2, 11**				**X**		
Procedures-at-risk							
Lead Screening	**14**					**R**	
Tuberculin Test							**R**
Cholesterol Screening							
STD Screening							
Pelvic Exam							
Anticipatory guidance	**2, 12**	**X**	**X**	**X**	**X**	**X**	**X**
Initial dental referral	**2, 13**						

Key: **X** = to be performed
S = Subjective, by history
O = Objective, by a standard testing method
R = Risk, performed for patients at risk

Notes referenced in the second column are found in **Section 1.6.4.5, *Notes from the EPSDT Charts***.

1.6.4.2 Early Childhood EPSDT Screening

Description	Notes	15 Mos.	18 Mos.	24 Mos.	3 Yrs.	4 Yrs.
History	**2**					
Initial / Interval	**2**	**X**	**X**	**X**	**X**	**X**
Measurements	**2**					
Height and Weight	**2**	**X**	**X**	**X**	**X**	**X**
Head Circumference	**2**	**X**	**X**	**X**		
Blood Pressure	**2**				**X**	**X**
Sensory Screening	**2**					
Vision	**2**	**S**	**S**	**S**	**O**	**O**
Hearing	**2**	**S**	**S**	**S**	**S**	**O**
Development/ Behavior Assessment	**2, 4**	**X**	**X**	**X**	**X**	**X**
Physical Examination	**2, 5**	**X**	**X**	**X**	**X**	**X**
General Procedures	**2, 6**					
Hereditary/Metabolic Screening	**2, 7**					
Immunization	**2, 8**	**X**	**X**	**X**	**X**	**X**
Hematocrit or Hemoglobin	**2, 10**	**X**				
Urinalysis	**2, 11**	**R**				
Procedures-at-risk						
Lead Screening	**14**			**X**		
Tuberculin Test	**2, 9**	**R**	**R**	**R**	**R**	**R**
Cholesterol Screening				**R**	**R**	**R**
STD Screening						
Pelvic Exam						
Anticipatory guidance	**2, 12**	**X**	**X**	**X**	**X**	**X**
Initial dental referral	**2, 13**				**X**	

Key: **X** = to be performed
S = Subjective, by history
O = Objective, by a standard testing method
R = Risk, performed for patients at risk

Notes referenced in the second column are found in **Section 1.6.4.5, *Notes from the EPSDT Charts***.

1.6.4.3 Late Childhood EPSDT Screening

Description	Notes	5 Yrs.	6 Yrs.	8 Yrs.	10 Yrs.	
History	**2**					
Initial / Interval	**2**	**X**	**X**	**X**	**X**	
Measurements	**2**					
Height and Weight	**2**	**X**	**X**	**X**	**X**	
Head Circumference	**2**					
Blood Pressure	**2**	**X**	**X**	**X**	**X**	
Sensory Screening	**2**					
Vision	**2**	**O**	**O**	**O**	**O**	
Hearing	**2**	**O**	**O**	**O**	**O**	
Development/ Behavior Assessment	**2, 4**	**X**	**X**	**X**	**X**	
Physical Examination	**2, 5**	**X**	**X**	**X**	**X**	
General Procedures	**2, 6**					
Hereditary/Metabolic Screening	**2, 7**					
Immunization	**2, 8**	**X**	**X**	**X**	**X**	
Hematocrit or Hemoglobin	**2, 10**	**R**				
Urinalysis	**2, 11**	**X**				
Procedures-at-risk						
Lead Screening	**14**					
Tuberculin Test	**2, 9**	**R**	**R**	**R**	**R**	
Cholesterol Screening		**R**	**R**	**R**	**R**	
STD Screening						
Pelvic Exam						
Anticipatory guidance	**2, 12**	**X**	**X**	**X**	**X**	
Initial dental referral	**2, 13**					

Key: **X** = to be performed
S = Subjective, by history
O = Objective, by a standard testing method
R = Risk, performed for patients at risk

Notes referenced in the second column are found in **Section 1.6.4.5, *Notes from the EPSDT Charts***.

1.6.4.4 Adolescence EPSDT Screening

Description	Notes	11 Yrs	12 Yrs	13 Yrs	14 Yrs.	15 Yrs	16 Yrs.	17 Yrs	18 Yrs.	19 Yrs	20 Yrs.
History	**1, 2**										
Initial / Interval	**1, 2**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Measurements	**1, 2**										
Height and Weight	**1, 2**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Head Circumference	**1, 2**										
Blood Pressure	**1, 2**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Sensory Screening	**1, 2**										
Vision	**1, 2**	**S**	**O**	**S**	**S**	**O**	**S**	**S**	**O**	**S**	**S**
Hearing	**1, 2**	**S**	**O**	**S**	**S**	**O**	**S**	**S**	**O**	**S**	**S**
Development/ Behavior Assessment	**1, 2, 4**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Physical Examination	**1, 2, 5**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
General Procedures	**1, 2, 6**										
Hereditary/Metabolic Screening	**1, 2, 7**										
Immunization	**1, 2, 8**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Hematocrit or Hemoglobin	**1, 2, 10**			**X**							
Urinalysis	**1, 2, 11**						**X**				
Procedures-at-risk											
Lead Screening											
Tuberculin Test	**1, 2, 9**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**
Cholesterol Screening		**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**
STD Screening		**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**
Pelvic Exam		**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**
Anticipatory guidance	**1, 2, 12**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Initial dental referral	**1, 2, 13**										

Key: **X** = to be performed
S = Subjective, by history
O = Objective, by a standard testing method
R = Risk, performed for patients at risk

Notes referenced in the second column are found in **Section 1. 6.4.5, *Notes from the EPSDT Charts***.

1.6.4.5 Notes from the EPSDT Charts

- Adolescent related issues (psychosocial, emotional, substance use and reproductive health) may necessitate more frequent health supervision.
- If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- At these points, history may suffice. If a problem is suggested use a standard testing method.
- By history and appropriate physical examination. If suspicious, by specific objective developmental testing.
- At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
- These may be modified, depending upon entry point into schedule and individual need.
- Metabolic screening (thyroid, PKU, galactosemia, etc.) should be done according to state law.
- Schedule(s) per Report of Committee on Infectious Disease, *1986 Red Book*.
- For low risk groups, the Committee on Infectious Diseases recommends the following options: A- no routine testing or B- testing at three times - infancy, preschool, and adolescence. For high-risk groups, annual TB skin testing is recommended.
- Present medical evidence suggests the need for reevaluation of the frequency and timing of hemoglobin or hematocrit tests. Therefore, one determination is suggested during each time period. Performance of additional tests is left to the individual practice experience.
- Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalysis. Therefore, one determination is suggested during each time period. Performance of additional tests is left to the individual practice experience.
- Appropriate discussion and counseling should be an integral part of each visit for care.
- Subsequent examinations as prescribed by dentist.
- Federal mandate: Screening for lead poisoning is a required component of an EPSDT Screen. Current CMS policy requires a screening blood level test for all Medicaid eligible children at 12 and 24 months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood test if there is no record of a previous test.